



CASE STUDY: ERITREA

Linking Food Security and Nutrition

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by

Lora Iannotti, LINKAGES (AED)

Margie Ferris-Morris, OMNI (John Snow, Inc.)

Kimberley Lucas, BASIS (IDA)

Anbrasi Edward Raj, QAP/JHU

For more information contact:

The LINKAGES Project

Academy for Educational Development

1255 23rd Street, NW

Washington, DC 20037

Tel: (202) 884-8700

Fax: (202) 884-8977

E-mail: linkages@aed.org

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List of Acronyms

GSE	Government of the State of Eritrea
GDP	gross domestic product
EDHS	Eritrean Demographic Health Survey
MOH	Ministry of Health
IDD	iodine deficiency disorders
VAD	vitamin A deficiency
IDA	ion deficiency disorder
TGR	total goiter rate
IMR	infant mortality rate
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
IMF	International Monetary Fund

GENERAL BACKGROUND

The Government of the State of Eritrea (GSE), located in the Horn of Africa, is bordered by Sudan to the west, Ethiopia to the south, Djibouti to the east, and the Red Sea to the northeast. Eritrea is a small country, approximately 125,000 square kilometers in size, with a population estimated between 2.6 and 3.6 million persons (FAO/UNICEF). Eighty-two percent of the population reside in rural highland and lowland areas. The per capita GDP is estimated at between \$100 and \$150 per annum (MOH 96/World Bank 94).

Eritrea was liberated from Ethiopia in 1991 after over 30 years of war. It is still in the process of clearing land mines and military ordnance from many of the rural areas. As a result of its generally arid and rugged landscape, agricultural and pastoral production in Eritrea accounts for only 11.25 percent of GDP, with livestock on average generating only six percent and agriculture only nine percent (to total 15%). Food security is not an issue of food self-sufficiency, but rather of export earnings and accumulation of foreign exchange earnings to use for food purchases at the national level and increasing rural incomes at the local level. The Eritrean economy is highly dependent on the service sector which accounts for 60 percent of the GDP (IBRD 1997). This sector includes retail trade, transport, and communications and is largely supported by expatriate Eritrean remittances. Aquaculture holds significant production potential but has yet to be revived to pre-war levels. The figures for agriculture fluctuate widely from year to year given the highly variable rainfall patterns and incidences of pest (locust) infestations. Though agriculture sustains 70-80 percent of the population (IBRD 1994), the bulk of this population still relies on food assistance in order to survive with over 50 percent of current food needs being met through food aid. The Eritrean government is firmly committed to reducing and quickly eliminating reliance on food assistance programs.

Approximately 51 percent of the population is less than 18 years of age. The female literacy rate is very low, (ten percent MOH estimates 32 percent) while male literacy is twice that of women. The population growth rate is three percent per annum. The life expectancy at birth is 46 years and the contraceptive prevalence rate is less than one percent. Fertility rates are high, with women having an average of seven children. Almost seven out of ten married women want either to space their next birth or to end childbearing altogether. Maternal mortality is very high at 998 deaths per 100,000 births (EDHS 1995).

There are two dominant ethnolinguistic groups in Eritrea the Tigrinya and the Tigre along with seven smaller minority groups. The Tigrinya, comprising 47.5 percent of the population of Eritrea, are noted as highland, peasant cultivators who are predominantly Orthodox Christians. The Tigre are lowland, settled pastoralist or agro-pastoralist Muslims. This latter group is geographically and ethnically fragmented and found throughout much of Eritrea. The Afar and Sahho comprise 10.5 percent and the Kumana and Nara comprise 4 percent of the population and have equal numbers of Christians and Muslims (Pool 1997).

Muslims reside predominantly in the lowlands and Christians in the highland areas. It is noted that large numbers of pastoralists lost their animals and became refugees in Sudan during the war.

Eritrea has 3,000 km of road of which 550 km are asphalt surfaced. The roads between the capital Asmara and the provincial centers are fair to good, while secondary roads are quite poor. There are two ports along the 1000 km of coast, Massawa and Asab.

I. PRIORITY I: IMPROVED MATERNAL, INFANT, AND CHILD NUTRITION, WITH A FOCUS ON PROGRAM QUALITY, DESIGN, AND IMPLEMENTATION.

A. SITUATION/PROBLEM OVERVIEW

Nutritional Status Infants and Children

Eritrea is a country with one of the highest rates of malnutrition in Africa, about one in four children under the age of three are either stunted or underweight. Malnutrition is one of the most significant health and welfare problems among infants and children, resulting from inadequate food intake and poor environmental health. The underlying causes of malnutrition in Eritrea correspond to those typically found in developing countries insufficient household food security, poor health care, unhealthy environment, illiteracy, and inadequate child care. An Eritrean Demographic Health Survey (EHDS) conducted in 1995/96 found the following prevalences for children under three years: 44 percent underweight (weight/age); 38 percent stunting (height/age), an indicator of longer-term malnutrition; and 16 percent wasting (weight/height), an indicator of acute malnutrition due to short-term shortages of food intake or disease. The most vulnerable period for malnutrition is between 4 and 21 months of age. Stunting, however, among children under five years in Eritrea peaks at 35 months, which is slightly older than the trend for children in other developing countries. This may be due to the conditions of protracted war in the country, as this age cohort were born immediately following the end of the war (Steele 1998).

The zones with higher stunting rates for children under three years include: Northern Red Sea (47 percent); Anseba (45 percent); and Gash-Barka (41 percent). The highest wasting rates (<three years) were found in the zones of Gash-Barka (23 percent), Southern Red Sea (23 percent) and Northern Red Sea (22 percent). These high rates of stunting demonstrate the long-term effects of drought and war, and low food production.

Nutritional Status Women

Three studies have looked at nutritional status of women in the past four years. Eritrea is among the countries with the highest degree of malnutrition in women. They are summarized in the box below. Malnutrition levels differed depending on residence - the highest found in the Southern Red Sea Zone (64 percent); and the lowest in the central zone (25 percent) (Draft Report Dr. M. Mehari, 1997).

Maternal Nutrition Status	BMI <18.1 (all degrees of malnutrition)	BMI <16 (severe malnutrition)
NSO DHS/1995	41%	n/a
MOH NHS/1994	54%	16%
IFSP/GS GTZ/1994	45%	6.6%

Information is lacking on vitamin A deficiency and iron deficiency anemia in women. The EDHS reported 61 percent of mothers with inadequate breastfeeding or complementary feeding behaviors (or 39 percent adequate). One issue contributing to the high maternal mortality rate is infibulation. More information is needed to fully address women's nutrition and health needs.

Micronutrient Deficiencies

Taken together, deficiencies of the micronutrients vitamin A, iodine, and iron affect the mortality and morbidity levels of a much greater number of people worldwide than protein energy malnutrition (Chandra 1990). The key micronutrient problems identified during a national micronutrient survey conducted by the Eritrean MOH in 1994, demonstrated that iodine deficiency disorders (IDD), vitamin A deficiency (VAD), and iron deficiency anemia (IDA) were all widespread and significant health problems in the country. Until recently, attacking the problems of VAD and IDA have not received the level of attention of that of iodine deficiency disorders.

Vitamin A Deficiency. In a Ministry of Health (MOH) supported micronutrient subnational study performed in 1993-1994, 6 percent of infants under one year age were found to have severely low levels of vitamin A and 29 percent of infants were found to be at moderate to high risk of developing vitamin A deficiency. The GSE has supplement and treatment protocols for vitamin A and in December 1997, commenced with VAC distribution with the National Immunization Days. A second VAC distribution is scheduled for May 1998.

Iodine Deficiency Disorders. In Eritrea, an estimated 787,000 persons are at risk for IDD. IDD leads not only to goitre in children and adults, but IDD in pregnant women can cause cretinism in developing fetuses and brain damage in infants. As many as 637,000 Eritrean children (aged 0-17 years) may have some form of brain damage stemming from IDD. Goiter prevalence studies shows the highest rates in the highland areas Akele-guzay, Serape, Senhit (> 30 percent) and lowest in Denkalia Semhar and in Barka (<10 percent) with a total goiter rate (TGR) of 22 percent (MOH 1996).

Given the extent of iodine deficiency found in the country, the GSE established a task force on IDD. The main strategy to combat IDD is through universal salt fortification. By the end of 1996, two major salt iodization plants were rehabilitated (formerly large industries in the 1970s) and small scale producers were in operation. Eritrea has revitalized its large salt producing industry, which produces enough salt to export 90 percent of production to Ethiopia and still supply the local Eritrean market. Not all salt is iodized, however, as the small scale producers around Massawa are not yet iodizing salt. USAID and UNICEF are supporting the small-scale producers in their efforts to begin iodization. Currently, the GSE estimates are that more than 75 percent of salt is iodized. The GSE is in the process of creating a law to prohibit the sale, production, and distribution of non-iodized salt for human and animal consumption within Eritrea.

Iron Deficiency Anemia. While data are sparse, the MOH found anemia to be high in infants, with 55.0 percent of infants (<12 months) with severe anemia and 36.7 percent with moderate anemia. One small survey reported that 92 percent of infants under one year are iron deficient (hemoglobin levels below the cutoff). Iron levels were found to be unacceptably low in children and pregnant women, and it is assumed that levels of anemia are high in Eritrea (based on high

prevalence of infant anemia, infections, fertility rates, deleterious practices such as blood letting, etc.) A nationwide anemia survey, planned for 1997, was postponed. Nationwide supplementation of pregnant women is prescribed in GSE health policies, however an assessment of program implementation is needed. One potential intervention to explore is dual fortification of salt with iodine and iron.

Health and Sanitation

There are strong regional differences in health status within Eritrea. Mother and child healthcare are not widely available in the country. Most rural villages do not have a trained village health worker. A World Bank (1994) report estimates that more than 40 percent of the population has no ready access (live within five km radius) to any kind of health services. Health clinics and stations (community-level posts) are the main health infrastructure. Each health station attempts to cover two to three times the population it is capable of serving. The GSE is in the process of decentralization, including the health budget. In terms of health services, regions have started to develop their action plans, and health financing and cost-sharing have been introduced. The GSE is working on strengthening national health information systems and quality control over pharmaceuticals.

The leading causes of death in Eritrea are from upper respiratory infections and malaria. The infant mortality rate is 72 deaths per 1,000 live births and the under-five mortality rate is 120 deaths per 1,000 live birth (EDHS), but varies widely around the country. For example, the IMR in the Hamasien Province is 97/1,000 (live births) as compared to 318/1,000 (live births) in Dankalia (World Bank 1994).

The current immunization rate (fully immunized 12-23 months) is about 41 percent, representing real progress over the past five years. An estimated 23 percent of child morbidity is due to diarrheal diseases (UNICEF). HIV prevalence rates in Eritrea are considered high (22.5/100,000) with Asmara and Asab having the highest reported cases.

Overall, only eight percent of the population has access to safe water. Many rural households have to travel between two to three hours to obtain water. Per capita daily water consumption is estimated at 2.5 liters (Morris 1997). The 1993 GSE/UNICEF report estimated that 21 of the 37 major diseases were water and sanitation related, and diarrheal disease accounted for 23 percent of child illness.

Food Production/Food Security

The main impetus behind most of the government's efforts to encourage agricultural development and growth is its need for food security. Thirty years ago, Eritrea was food self sufficient while today it has not been able to meet more than half of its cereal requirements. Rural household food security depends on food production and related factors such as land holding size, crop production levels, and availability of sources of supply for agriculture. In one GTZ study (1994) in Gash-Setit, only 20-37 percent of the rural households were determined food secure.

Urban food security is more dependent on income and food price.

There are six agro-ecological zones in Eritrea. Only one of these zones, the highland greenbelt zone with its two rainy seasons per year (Araia et al 1994), can support permanent crops such as coffee without irrigation. This zone has an average of 1000 mm of rain per year as compared to

only 400 mm on average in other highland and lowland zones (IBRD 1994). The agricultural system in Eritrea is similar to that found in Ethiopia, consisting of mixed, small-scale farms in which oxen are used extensively for plowing. Over 95 percent of all agriculture in Eritrea is rainfed. The limited amount of irrigated lands are used to produce high value (export) crops such as fruits, vegetables and oilseeds (IBRD 1994:63). IMF figures (1996) note that the four principal food production areas (all highland areas) are Seraye, Gash-Serit, Barka, and Akeleguzay. These areas contain less than 50 percent of the population of Eritrea but produce 70 percent of the country's total crop production. Sorghum represents 44 percent of production, while barley represents 20 percent, teff nine percent, wheat seven percent, and maize only four percent (ibid). However, maize yields (1 mt /ha) are usually higher per ha than sorghum (0.9 t/ha).

Current situation

September dry spells and insufficient October rainfall levels reduced November harvests of the main season cereal crops. These crops are noted to be at the same reduced level of the previous two years. As a reflection of dwindling food stores, cereal prices began to rise steadily in April and continue to do so. The fact that Ethiopia is also facing declines this year means that imports from Ethiopia will be substantially reduced as well. Given that even in the occasional years of good rainfall, Eritrea does not produce enough to cover its subsistence needs, Eritrea's food security situation is expected to continue to deteriorate in 1998 (FAO/GIEWS 11-97).

Food Consumption

Grain is the main staple with little variety in the diet. It is estimated that the average daily caloric intake following a relatively good harvest was 1750 kilocalories or about 83 percent of the recommended 2100 kilocalories (93 percent of recommended level if using Ethiopian standards). Food consumption within the household is often gender biased. Adult males and laborers consume food first, women and children second.

In the agropastoral lowland zones, the key foods consumed are sorghum, millet, butter, and meat. In the highland agricultural zones, the key products consumed are wheat, maize, teff, and barley along with various pulses (Araia et al 1994 :87; Cliff 1988) and only half as much butter, milk, and meat as in agropastoralist areas. In general, meat consumption is insignificant, except for middle and higher income urban families.

Lowland pastoralist and agro-pastoralist communities consume the most milk (goat's milk) up to a liter per person per day. Milk is either smoked, boiled, or eaten as cheese. Herd size needs to be large enough to sustain at least this consumption level for the household. In hungry periods when there is a lack of pasture land and grain prices rise, livestock prices fall as farmers sell their livestock to purchase cereal.

With 1060 km of seacoast, the fishing potential of Eritrea has long been underexploited. The annual catch is less than two percent of the annual sustainable yield (UNICEF). While this is an area of opportunity for income generation, interventions to combat the culturally-limited demand for seafood would need to be addressed. In Eritrea, Christians traditions link seafood with denial/penance (eaten primarily during Lent) and Muslims bar some kinds of seafood. More appealing methods of preparation could be introduced (UNICEF 1994). Currently, the Ministry of Marine and Fisheries is undertaking a program to promote fish consumption among the

Eritrean population. The MOH highly supports this venture, realizing both the economic and nutritional benefits of increased fish consumption.

Young Child Feeding Practices

Breastfeeding in Eritrea is nearly universal. By 10 11 months, 96 percent of infants are still being breastfed, and even by 16 17 months, 85 percent of infants are still breastfed (EDHS 1995). The medium duration of breastfeeding is 22 months. Culturally, breastfeeding has long been accepted as the main source of nutrition for infants and young children in Eritrea. However, exclusive breastfeeding is not widely practiced. Since liberation in 1991, 450 provincial health workers were trained in supportive breastfeeding policies and practices.

By four months of age, 35 percent of Eritrean infants are receiving inferior liquids (such as sugar water, formula, juice) and solid foods. Introducing liquids and solids increases their exposure to pathogens, putting the infants at greater risk for diarrheal disease. Infant formula is not given to most Eritrean children and bottle feeding is rare.

Inadequate complementary feeding practices as well as poor quality weaning foods in Eritrea may account for the high rates of stunting (56.5 percent for 24 35 months) and wasting (25.3 percent for 12 23 months). Injera (bread made from fermented grains), gat (porridge), sibko, ajja, and other foods prepared from flour and cereal are the common weaning foods in Eritrea. Tea is also frequently given to young children. Protein foods are less common with only 16.1 percent of breastfeeding children receiving meat, poultry, fish, or eggs. Less than half (45 percent) of the infants age six to nine months are fed the recommended complementary foods in addition to breastmilk (EDHS). A recent study carried out by BASICS found that young children are given very small portions of foods, as well as foods prepared for families which are often very spicy. Income and knowledge constraints were cited as the primary limiting factors to proper complementary feeding (Steele 1998).

B. FOOD SECURITY AND NUTRITION LINKAGES

Livelihoods and Coping Mechanisms

In lowland areas, agropastoralists depend on their livestock (goats, sheep and camels) for livelihood to a greater extent. Livestock is used as capital to be sold during hard times. Pastoralists have also been known to bleed their animals for blood which is consumed as food. People will sell personal goods such as pots, and pans, and jewelry during hard times to acquire cash for food purchase. A widely used asset is labor such as construction, well-digging, herding, collecting firewood, or agricultural labor.

All rural peoples gather wild foods such as berries, wild green leaves, and tubers. In the highland areas, wild leaves are gathered and consumed during the rainy season as a fairly common part of their diet. There is no clear picture of the how often or to what extent these practices impact household diets. However, it is a key component of most household food security practices.

The population in the highland areas is predominantly farmers. Livestock holdings are not as significant and cattle are of greater worth for their draft value. The government owns all the land in Eritrea, so land is not a redeemable asset. However, land tenure issues are still subject to public and private debate. The GSE is modifying the existing land tenure arrangement, the *diesa*

system, in which the land surrounding a village is considered common property of the community. The GSE plans state that farmers will receive a lifetime deed to the land. Land reform measures aimed at increasing security of usufruct tenure were expected to improve agricultural performance, but the effects of these changes are as yet unclear (IBRD 1994).

Food Security and Crop Failure

Access to food is the major issue affecting the life and well being of Eritreans. The civil war displaced large numbers of farmers and herders, disrupted the infrastructure system, and diminished a large portion of their assets. Agricultural production is low and only six percent of cultivated land is under irrigation. The Horn of Africa has experienced drought (where annual rainfall falls below the 550 mm mean) for approximately 12 of the past 20 years.

In addition to the lack of draft animals, many agricultural practices are inefficient seed is broadcast; cultivation is minimal; and there is a need for better seed varieties. These constraints place subsistence farmers and herders at risk.

The most threatening disaster is crop failure. Crop failure can be due to drought and untimely rains, or pests such as Desert Locust (*Shistocerca gregaria*) and Army Worm (the pupae stage of a butterfly). In addition to these pests, there is a growing problem with the parasitic weed *Striga* (*Striga helmantica*), which affects sorghum fields.

Women's Role in Food Security

Women in Eritrea are active in most areas of productive life but are at a distinct social and economic disadvantage, lacking the access to education, land, and credit of their male counterparts. Though officially granted de jure rights, women in the rural areas are still under the de facto rule of customary systems. Practices that significantly increase maternal deaths such as infibulation are widespread, especially in the lowlands of the country. With the exception of the matrilineal Kunama, women are at the mercy of husbands, fathers, and sons for access to land and resources. The only rural, female-headed households are those of widows who are noted as the most at risk of food insecurity.

Given that there is a clear correlation between economic and social development and the educational levels attained by women, it is imperative that women's education be addressed. Further, given that incremental increases in women's income are shown to be spent on household food consumption (Gittenger 1990: 19), targeting the income generating abilities (access to education, credit, markets, and inputs) is a key component of improving food security and nutritional status of the household. The World Bank (1994) notes that several microcredit schemes targeting women have been successfully implemented in several small areas of the country by the National Union for Eritrean Women. They recommend that these microcredit schemes be expanded to other areas of Eritrea.

II. PRIORITY II: IMPROVED USE OF INFORMATION AND ADVOCACY TO INFLUENCE POLICIES, STRATEGIES, AND PROGRAMS

A. SITUATION/PROBLEM OVERVIEW

Nutrition and Food Security Policies

In August 1996, the Ministry of Health drew up two key policy documents to address nutritional and micronutrient deficiencies. These were the Policy Guidelines on Food Security and Nutrition to implement coordinated health and agriculture sector interventions aimed at producing sustained long-term nutritional improvements, and the Maternal and Child Nutrition Action Plan (1997-2001).

The primary objectives of the Policy Guidelines on Food Security and Nutrition are:

- to eliminate iodine deficiency disorders by 2000;
- to virtually eliminate vitamin A deficiency by 2000;
- to reduce iron deficiency anemia by one-third by 2000
- to achieve food security at the national level in the coming five years;
- to incorporate food and nutrition objectives within the health, agriculture, poverty alleviation, education, industry and other sectoral priorities; and
- to develop and maintain the necessary technical, managerial and institutional capability to accomplish the above objectives.

The MOH intends to achieve these objectives via a number of strategies including education; EPI-plus (with VAC distribution); IMCI (Integrated Case Management for Illness) with a strong counseling emphasis on nutrition; iron/folate supplements to pregnant women; growth monitoring; and targeted supplementary feeding (although the later will be phased out over five years). The strategy for preventing micronutrient deficiencies will center on increasing the availability and consumption of micronutrient- rich foods via strategies to improve food production; processing and preservations; food fortification and fortification of weaning foods; salt fortification (well underway); and short-term micronutrient supplementation. Public health measures to support the above will include improving the supply of safe and adequate water.

The Maternal and Child Nutrition Action Plan describes the organization framework for carrying out nutrition and health programming, including the need for capacity building; developing agricultural strategies; research towards new approaches; and tracking progress in implementing the Action Plan. In addition to the key achievements of the MOH over the past five years (mentioned previously), the key challenges which need to be addressed to achieve the Nutrition Action Plan are

- shortage of technical and managerial resources to plan and implement activities;
- gaps in awareness and understanding among general public about malnutrition and the actions needed;

- lack of coordination mechanism at central and zonal levels to ensure appropriate multi-sectoral actions for addressing key causal factors of food insecurity and malnutrition; and
- limited information for planning.

Food Security Information Systems

The most serious needs for food security information are the reliable quantification of the national cereal import requirements and the early analysis of household information for identification of localized food crisis areas. There is a lack of clarity in the identification and criteria of vulnerable groups and how food aid is to be distributed and the modalities of a food relief operation. The decision process that would alert a food crisis, the steps leading to changing a cash for work program into a relief food distribution program, when and for how long a food aid distribution would take place, is still unclear.

Early Warning Food Information System (EWFIS). The Early Warning and Food Information System (EWFIS) is a program within the Ministry of Agriculture (MOA) with responsibility to compile early warning information concerning food security and to coordinate government and international intervention in the event of a crop failure emergency. The EWFIS was recently mandated by the government and is currently assisted by the Food and Agricultural Organization (FAO) with Italian government donations.

Information from this EWFIS program will be integrated into the Intergovernmental Authority for Development (IGAD) Regional Early Warning and Food Information System in Djibouti which publishes the IGAD Food Situation Report . Compiled information, in turn, will benefit the Global Information and Early Warning System (GIEWS) located at FAO in Rome, Italy.

Regional IGAD Program. The EWFIS will form part of a regional program to strengthen food information activities in the seven IGAD countries. The regional program, based at the IGAD Secretariat in Djibouti, has been developing methodologies for early warning in the sub-region. The goals are to produce a regular and quick national assessment in map form (GIS) classifying areas within each member country according to food security risk. The regional EWFIS program gathers meteorological, remote sensing, market price, health, and nutrition data.

For Eritrea, food security is not an issue of food self-sufficiency but rather of export earnings and accumulation of foreign exchange earnings to use for food purchases at the national level and increasing rural incomes to improve nutritional levels through the purchases of food at the local level. Given the drought-prone nature of the region and consequent lack of soil moisture, it is expected that provision of fertilizers can do little to increase production. FAO estimates of uncultivated, arable land show that significant production increases could come from increasing cultivation and irrigation of new land, especially in the lowlands.

In this context of low productivity agriculture and concentration of production in particular regions, it becomes even clearer that income and poor market structures are the key constraints to improving food security and nutrition in Eritrea (IBRD 1994). To this end, food aid projects in the country have been converted to cash-for-work public works projects for improving necessary infrastructure and improving the access to food and the ability of participants to purchase food in periods of transient food insecurity.

The Eritrean Food Security policy pushes not only increased production, but increased export earnings and the increased use of food/cash for work social safety net.

Development aid from the United States will continue to focus on use of bilateral and PL 480 Title III resources to assist in the reconstruction of agricultural rural roads, rural banking and credit, and farmer education and organizations in order to expand rural income and trade as a means to increasing food security (USAID/CP 1998). The chief constraints to improving food security and nutritional status in the country are noted as low productivity levels, widespread poverty, unreliable rainfalls, and chronic food shortages throughout the country (IBRD 1994:59).

III. PRIORITY III: IMPROVED MATERNAL AND CHILD NUTRITIONAL STATUS IN EMERGENCY AND REFUGEE SITUATIONS

A. SITUATION/PROBLEM OVERVIEW

Food shortage as a result of drought or pestilence is the greatest disaster risk to Eritrea. The GSE is aware of potential disasters and has made initial efforts to address disaster preparedness through the establishment of governmental structures as the Eritrean Relief and Refugee Committee (ERRC), the Eritrean Grain Board (EGB), and the Early Warning Food Information System (EWFIS). The activities of these institutional structures, (early warning, disaster assessment and response capacities) are still emerging.

Eritrean Relief and Refugee Commission (ERRC). The Eritrean Relief and Refugee Commission (formerly ERRA and CERA) is the government agency responsible for relief, rehabilitation and refugee activities that concern Eritrean refugees. In a recent statements, the ERRC indicated it will shed relief functions to specialize in rehabilitation, and repatriation. The ERRC's activities include policy formulation on food aid including food monetization; supervision of NGO activities; and coordination of the rehabilitation and the PROFERI program.

In a food crisis, the ERRC is responsible for identifying the vulnerable groups and locations with the assistance of the EWFIS. In 1996, ERRC began a large-scale vulnerability census in which teams reviewed village criteria on vulnerability. The criteria is based upon the premise that persons entitled to a vulnerability status will be those who are "not able to work."

In vulnerable areas, the ERRC would give cash to the vulnerable beneficiaries through the local government baito (village governance) structure. In the event of a frank emergency, food aid would be delivered without a cash component. The EGB would make grain available and would find commercial transport.

Eritrean Grain Board (EGB). The Eritrean Grain Board was set up by the GSE in 1993 with the role to stabilize market pricing and to maintain an emergency grain stock. In late 1996, with assistance of Canadian Food Grain Bank through CIDA funding, it took on the additional role to help collect and analyze food security information at the household level. This information will be transmitted to the EWFIS unit at the MOA. With the monetization of all food aid, the EGB will have all responsibility for a food balance sheet, accounting food aid storage and food delivery in the county.

USAID has provided technical support to Africare in Eritrea mostly in the agriculture sector. For fiscal year 1998, Africare has requested 430 metric tons of Title II food aid. At present this is the only Title II food assistance in the country.

IV. CONCLUSION

The food security and nutrition situation in Eritrea is complex given the post-war context and the ongoing drought and poverty conditions. Rates of malnutrition are among the highest in the world. The situation is especially tenuous for infants, children under three years, and women. Micronutrient deficiencies in vitamin A, iron, and iodine are also problems of great magnitude. There appears to be a direct relationship of the nutrition problems with the food insecurity issues of availability, access, and utilization. Eritrea is heavily reliant on food aid and imports as the country can produce only half of its food requirements. There are few other income-generating activities in the country to provide households with the means to purchase additional foods. Other problems related to the utilization of food, such as disease, limited access to healthcare, and low levels of knowledge, also contribute heavily to the nutrition problems.

Although the Government of Eritrea and others are beginning to address these problems (i.e. iodine fortification), significantly more resources and programming services are necessary across the various sectors.

**** Interventions to address the problems identified in this Case Study on Eritrea have been proposed by the Cooperating Agencies of LINKAGES, OMNI, BASIS, and QAP. They may be found in the document - Priority Interventions: Linking Food Security and Nutrition, April 1998.**